

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1.
 - a. Whether there should be additional reimbursement for date of service 01/08/02.
 - b. The request was received on 03/21/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Position Statement located on the Table of Disputed Services
 - b. HCFAs-1500
 - c. TWCC 62 forms
 - d. EOBs from other insurance carriers
 - e. Medical documentation
 - f. Additional Documentation received by the Division on 06/04/02
 - g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Responses to the Request for Medical Dispute Resolution received by the Division on 03/09/02, 05/20/02, and 07/22/02.
 - b. HCFAs-1500
 - c. TWCC 62 forms
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/05/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 07/10/02. The response from the insurance carrier was received in the Division on 07/22/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services
"We feel an additional payment is due to us for the equipment we gave this patient. We have submitted all necessary documentation including payments by other carriers. This carrier still denies payment."

2. Respondent: Letter dated 07/18/02
 “Please be advised we have additional documentation to attach. These charges have been reviewed on appeal and we find them to be reasonable reimbursement for the services provided.”

IV. FINDINGS

- Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 01/08/02.
- The carrier denied the billed charges by denial code, “M – No MAR”.
- This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider’s TWCC-60, the amount billed is \$155.00; the amount paid is \$85.00; the amount in dispute is \$70.00.
- The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
01/08/02	E1399 (Water circulating pad)	\$155.00	\$70.00	M	DOP	Rule 133.307 (g) (3) (D); HCPCS code ; MFG DME GR (IV)	The provider billed a water circulating pad by using HCPCS code E1399 as directed by MFG DME (IV). The reimbursement data evidence submitted by the provider proved to be insufficient to meet the criteria of Rule 133.307 (g) (3) (D) which states, “if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title...” The provider submitted three EOBs from other carriers. None of the EOBs submitted identified the disputed DME E1399 as a water circulating pad. Each EOB for the HCPCS E1399 billed \$155.00 with the reimbursement by other carriers of \$155.00. However, there were no corresponding HCFAs from the other carriers identifying what the DME item on the submitted EOBs were. The provider, based on the HCFAs submitted for the DOS in dispute, does provide the descriptive information on their HCFAs. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. Without identification of the HCPCS code E1399 in dispute, the provider failed to meet the criteria of Rule 133.307 (g) (3) (D) by submitting insufficient documentation to establish that the payments made by the carrier were not fair and reasonable. No reimbursement is recommended.
Totals		\$155.00	\$70.00				The Requestor is not entitled to reimbursement.

MDR: M4-02-3167-01

The above Findings and Decision are hereby issued this 14th day of February 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm